STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	06/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: June 25, 26, 27, and 28, 2012 Survey team: Michelle Hosteter, RN, TC Michelle Carter, RN Rita Mullen RN Facility number : 012285 Provider number: 155777 AIM number : 201006770 Census bed type: SNF: 51 SNF/NF: 10 Residential: 46 Total: 107 Census payor type: Medicare: 30 Medicaid: 2 Other: 75 Total: 107 Sample: 15 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The submission of this POC does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health Campus.The facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This POC will serve as the credible allegation of compliance with all federal and state requirements governing the management of this facility.The procder respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 7/9/12 Cathy Emswiller RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of abnormal lab values, resulting in a delay in treatment. This deficiency affected 1 of 15 residents reviewed for	F0157	1. Res # 20 lab results were called to the physician with new physician order noted. 2. All current residents labs were audited to ensure notification to the physician of the current lab	07/29/2012

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	physician notification in a timely manner. (Resident #20) Findings include: The clinical record for Resident #20 was reviewed on 6/27/12 at 2:15 P.M. Diagnoses for Resident #20 included, but were not limited to, right patella fracture, left elbow fracture, and a fall history. On 6/21/12, physicians orders indicated a lab order for CBC (Complete Blood Count) and BMP (Basic Metabolic Panel). Faxed lab results dated 6/22/12 indicated the facility received the results with abnormal lab values at 5:37 P.M. Sodium results were 126.0 mmol/L. The stated reference range was 136.0 - 145.0 mmol/L. Nursing Notes, dated 6/23/12 at 9:00 A.M., indicated the physician was notified of abnormal lab values. "Spoke to on-call regarding resident's low Na (sodium) level. On-call states to repeat BMP on 6/25/12 and monitor during the remainder of weekend and notify physician on-call if more SX (symptoms) arise." The next entry in Nursing Notes, dated 9:40 A.M., stated the following: "On-call		results. 3. All licensed nurses have been inserviced on lab reporting to the physician per policy and procedures. All lab results will be audited 5 days per week x 2 months, then 4 days per week x2 months, 3 days per week x2 months, and then as needed by DHS or designee.4. Results from audits will be reviewed monthly during QA commitee for 6 months.	

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	called this writer back and states to STAT labs and begin IV (intravenous) 0.9% (Indicates sodium chloride, traditionally known as normal saline and used to replace lost fluids.) and then repeat same labs on Monday." During an interview with the DHS on 6/28/12 at 5:20 P.M., she indicated the physician was not notified of abnormal lab values, promptly. She further indicated as the DHS, she expected physicians to be notified of condition changes, promptly. 9:00 A.M. the next morning was not a prompt and timely physician notification, she indicated. 3.1-5(a)(2)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure staff immediately reported alleged allegations of abuse as outlined in the policy to notify the Executive Director for 2 of 3 investigations for abuse reviewed. [Resident #21 and Resident #64] Findings include: During the entrance conference on 6/25/12 at 10:30 A.M. the Executive Director was requested to provide facility investigations to determine if the facility was implementing proper procedures for allegations of abuse. On 6/25/12 at 2 P.M. the Director of Health Services (DHS) provided the investigations for abuse. 6/26/12 at 9:00 A.M. the investigations of abuse were reviewed. An investigation dated 3/1/12 at 18:10 (6:10 P.M.) indicated "...CRCA #7	F0226	1. Abuse allegations cited were previous and had been reported per state guidlines. Could not immediately correct this previous issue.2. All residents could be affected by this deficient practice.3. All employees will be inserviced regarding the issue of notifying the Executive Director immediately of any suspested abuse. The exact time of this notification will be documented on investigation and provided on State Incident report form.4. QA&A committee reviews all abuse allegation monthly, but will now audit for Executive Drector notification time and follow up on any discrepencies.	07/29/2012

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	(Certified Resident Care Associate) reported at 17:50 P.M. (5:50 P.M.) to the SSD (Social Service Director) that she thinks she witnessed abuse from QMA #8 (Qualified Medication Aid) toward another Resident on the legacy unit. SSD immediatly (sic) notified writer. (the writer is the DHS)... CRCA #7 indicated that Resident #21 was standing up and causing his chair alarm to sound. CRCA #7 heard QMA #8 yell "Sit down" to this Resident. CRCA #7 also stated the she then saw QMA #8 walk over the resident and place both of her hands on his shoulders and physically sit him down in his chair. CRCA stated that seeing this incident made her very uncomfortable and she immediately reported it to the first manager she saw..." There was no indication in the investigation of notification of the Executive Director. Another investigation dated 4/25/12, indicated "... at 2300 (11:00 P.M.) this writer (DHS) received a call from LPN #9 regarding Resident #64 concern of mistreatment by CRCA #10, who assisted with the Resident's transfer on the morning of 4/25/12. The LPN informed this writer that Resident #64 does not want CRCA #10 in her room or assigned to her care again. The resident also stated to LPN #9 that CRCA #10 got in her face and said in a stern tone "Don't			

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	cuss at me or I will leave, I get enough of that at home." Resident #64 also stated to LPN #9 that CRCA #10 was rough with her bad leg and refused to pad the hoyer sling with to els (sic) as the staff normally does to prevent the sling from hurting her leg...." The investigation did not indicate the Executive Director was notified. On 6/26/12 at 4:10 P.M. the DHS indicated in an interview that she had verbally notified the Executive Director of both incidences of abuse and did not document regarding his notification. She further indicated that she had instructed staff during inservices and training to notify the nurse in charge and her of allegations of abuse. In interviewing staff for abuse on 6/27/12 at 2:00. P.M., 4 of 5 staff did not know to notify the Executive Director of allegations of abuse. [LPN #6, LPN #16, CRCA #18, and CNA #17] The DHS provided a policy for abuse on 6/25/12 at noon a policy on abuse. The policy was titled "Abuse and Neglect Procedural Guidelines" dated 11/2010 indicated, "...d. Identification...iv. IMMEDIATELY notify the Executive Director. IF the Executive Director is absent they may appoint a designee..."			

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	3.1-28(a)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure appropriate nursing assessments were completed, based on the family's reports of condition changes made to nursing staff. This failure affected 1 of 15 residents reviewed for appropriate nursing assessments. (Resident #20) Findings include: The clinical record for Resident #20 was reviewed on 6/27/12 at 2:15 P.M. Diagnoses for Resident #20 included, but were not limited to, right patella fracture, left elbow fracture, and a fall history. 1. A physician fax dated 6/20/12 at 1815 (6:15 P.M.), indicated the "resident behaving bizarrely, since starting Cymbalta (antidepressant). Family wishes he no longer take this medication." The fax indicated the need for an order to discontinue the Cymbalta. The physician indicated agreement to discontinue the	F0309	1. Resident 20 physician was notified of change in condition related to resident behavior while taking Cymbalta and urine being dark in color and not drinking much fluids. 2. All current residents have been audited to ensure any change in condition that the resident physician has been notified of the change in condition. 3. All licensed nurses have been inserviced on completing and documenting assessments when a resident or family voices concerns or nurse observes a change in condition. All licensed nurses have been inserviced on documenting the date and time of the assessments.All residents noted to have a change in condition upon reviewing 24 hour nurse report sheets during clinical meeting will be audited for completion and notification of change of condition to the physician 5 days per week for 2 months per the director of nursing and or designee, then 4 dyas per week for 2 months then 3 days per week for 2 months.4. All audits will be reviewed	07/29/2012

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	Cymbalta. Nursing notes did not indicate any behavior assessments were completed. During an interview on 6/28/12 at 5:20 P.M., with the Director of Health Services (DHS), she indicated Resident #20 was not assessed for behaviors. 2. A physician fax dated 6/21/12 (no time indicated), stated "..family reports res' (resident's) urine is dark in color, not drinking much fluids. Labs to be done 6/22." A Skilled Nursing Assessment and Data Collection form dated 6/21/12 at 10:00 A.M. indicated Resident #20's urine color/clarity was yellow. During an interview with the DHS on 6/28/12 at 5:40 P.M., she indicated she did not know what time the physician was notified regarding the family's report of dark urine. Nursing notes did not indicate any re-assessments of urine or vital sign assessments after the family reported a dark color to his urine. In fact, the only documentation of dark colored urine was indicated on the fax dated 6/22/12. A physician's order dated 6/25/12 indicated an order for Cipro (antibiotic) for treatment of an urinary tract infection.		monthly for 6 months in QAA commitee.	

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	3.1-37(a)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure cleanliness, proper food labeling and storage. These deficiencies had the potential to affect 48 of 51 residents who dine from the kitchen. Findings include: 1. During the main kitchen tour on 6/25/12 at 10:40 A.M. with the Director of Food Services (DFS), the following were found without a label and without a date of opening: In the freezer: 3 frozen hamburger patties in a Ziploc bag, one brown bag of frozen tater tots, and frozen potato fries in a Ziploc bag. In the refrigerator: 33.8 ounce container of lime juice, 16 ounce container of low sodium chicken base, hot dogs in a Ziploc bag, and two 16 ounce plastic containers of strawberries. In dry storage: an opened bag of whole	F0371	1. All unlabeled, undated food items identified were immediatley destroyed. All areas identified as being dirty were immediatley.2. All residents have the potential to be affected by this deficient practice.3. All dietary staff will be inserviced by home office dining services support on kitchen sanitation and rules of food labeling, including dating of opened item. Director of Food Services(DFS) has developed and implemented a new individualized cleaning schedule with a check off system. DFS, ADFS or designee will inspect kitchen daily and compare with cleaning schedule to assure persons responsible for cleaning specific areas have done so. 4. As current QA&A member, DFS will review with committee monthly the kitchen sanitation inspections for policy adherence.	07/29/2012

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	grain brown rice, and an opened bag of elbow macaroni. During the main kitchen tour, an interview with the DFS indicated all opened items needed a date of opening and a label for contents. She indicated she was on vacation last week, but, the kitchen staff should have dated and labeled these items. She indicated the main kitchen serves the health care residents and the assisted living residents. 2. During the main kitchen tour on 6/25/12 at 10:40 A.M. with the DFS, the kitchen was not clean. Floors were dirty, sticky, and debris covered. 4 of 4 stainless steel shelves were dusty and contained debris. Clean dishes, as indicated by the DFS, were stored on a lower level stainless steel shelf that was dusty and had debris on it. The knife storage wall unit was covered with debris at the top. The ice cream cooler sliding doors were sticky and covered with ice cream smears. During the main kitchen tour, an interview with the DFS indicated a stainless steel shelf was dirty and should not have clean dishes stored on it. She indicated she was on vacation last week and the kitchen staff left a mess for her to clean.			

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	3.1-21(i)(1)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review, observation and interview the facility failed to ensure correct pharmacy labels were kept on medications being passed to residents.	F0431	1. Resident #23 had a direction change sticker applied on 6/27/12 to the medication in question Resident number # 55 had a direction change sticker applied	07/29/2012

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	This affected 3 of 41 residents observed during medication pass. [Resident #23, Resident #29, and Resident #55] Findings include: During medication pass on 6/26/12 at 11:10 A.M. LPN (Licensed Practicing Nurse) #12 was giving Resident #29 her medications. LPN #11 was giving the resident Vancomycin. LPN #12 handed the bottle she was withdrawing the liquid Vancomycin from. The bottle had no resident's name on it. The label of the medication indicated for intravenous use only. The MAR (Medication Administration Record) dated June 2012 indicated the Vancomycin was to be given orally. There was no label on the bottle indicating it was for oral use. In an interview with LPN #12 on 6/26/12 at 11:15 A.M. she indicated there should be a label with the patients name and a sticker indicating a different route on the bottle. In an interview with the DHS (Director of Health Services) on 6/28/12 at 6:00 P.M. She talked to pharmacy and they indicated they sent a batch of bottles in plastic wrap for Resident #29 that had a sticker on the outside that indicated for oral use only and the resident's name and other		on 6/27/12 to the medication in question. Resident number #29 had a new label obtained for the medication in question.2. Current residents medications have been audited to ensure medications have the correct directions and label on medication that matches the physician order and if order was changed a direction change sticker has been applied when order changed. 3. All licensed nurses have been inserviced on pharmacy label policy and procedure consisting of direction change stickers to be applied to label when orders are changed. All new or clarification of medication orders will be checked against the label of the medication received from pharmacy 5 days per week by DHS or designee for accuracy for 2 months then 4 days per week for 2 months then 3 days per week for 2 months. 4. Results from audits will be reviewed monthly during QA commitee for 6 months.	

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	155777	A. BUILDING 00 B. WING	06/29/2012

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	information is kept in a bag that the medication comes in. During medication pass on 6/27/12 at 2:30 P.M. RN #13 passed medications for Resident #55. The RN passed the medication card and stated she was going to give two calcium tablets. The label on the card indicated, 'Calcium 600 mg+ Vitamin D 400 IU (International Units) 1 tab p.o. (by mouth) TID (three times a day). In an interview with RN #13 indicated at that time that the card label was incorrect. She indicated the MAR for June indicated the resident is to get two tablets of Calcium three times a day. She indicated the order had been changed recently and should have been changed. During medication pass on 6/27/12 at 3:30 P.M. LPN #14 was passing medication to Resident #23. LPN #14 indicated she was going to give the resident eye drops. The bottle of medication label indicated Sulfacetaminde 10% 2 drops to right eye every 3 hours. In an interview with the LPN at this time, she indicated the MAR and physicians order indicated to give 1 drop in left eye every 3 hours. She indicated the label was			

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	incorrect. She indicated they usually put a order change sticker on the bottle that indicates to see MAR. She indicated he only had a few more doses to give tonight and medication is discontinued tomorrow. On 6/28/12 at 9:30 A.M. the DHS provided a policy dated 2/1/10 from PCA Pharmacy titled. "Medication Ordering and Receiving From Pharmacy " IC10: Medication Labels. The policy indicated "...Labels are permanently affixed to the outside of the prescription container...If a label does not fit directly onto the product...the label may be affixed to an outsider container or carton, but the resident's name, at least, must be maintained directly on the product container..." She also indicated that this was the only pharmacy policy she has. She indicated the procedure of putting on an order change sticker is not indicated in a policy. 3.1-25(j) 3.1-25(k) 3.2-25(l)			

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F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the physician was notified of abnormal lab values, resulting in a delay in treatment. This deficiency affected 1 of 15 residents reviewed for physician notification of abnormal lab values, in a timely manner. (Resident #20) Findings include: The clinical record for Resident #20 was reviewed on 6/27/12 at 2:15 P.M. Diagnoses for Resident #20 included, but were not limited to, right patella fracture, left elbow fracture, and a fall history. On 6/21/12, physicians orders indicated a lab order for CBC (Complete Blood Count) and BMP (Basic Metabolic Panel). Faxed lab results dated 6/22/12 indicated the facility received the results with abnormal lab values at 5:37 P.M. Sodium results were 126.0 mmol/L. The stated reference range was 136.0 - 145.0 mmol/L. Nursing Notes, dated 6/23/12 at 9:00	F0505	1. Resident 20 had lab results called to the physician and order noted2. Current residents labs have been audited 3. All licensed nurses have been inserviced on lab reporting to physician policy and procedures. All lab results will be audited 5 days per week x 2 months, then 4 days per week x2 months, 3 days per week x2 months, and then as needed by DHS or designee.4. Results from audits will be reviewed monthly during QA commitee for 6 months.	07/29/2012

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	A.M., indicated the physician was notified of abnormal lab values. "Spoke to on-call regarding resident's low Na (sodium) level. On-call states to repeat BMP on 6/25/12 and monitor during the remainder of weekend and notify physician on-call if more SX (symptoms) arise." The next entry in Nursing Notes, dated 9:40 A.M., stated the following: "On-call called this writer back and states to STAT labs and begin IV (intravenous) 0.9% (Indicates sodium chloride, traditionally known as normal saline and used to replace lost fluids.) and then repeat same labs on Monday." During an interview with the DHS on 6/28/12 at 5:20 P.M., she indicated the physician was not notified of abnormal lab values, promptly. She further indicated as the DHS, she expected physicians to be notified of condition changes, promptly. 9:00 A.M. the next morning was not a prompt and timely physician notification, she indicated. 3.1-49(f)(2)			

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F9999	1. 3.1-50 Clinical records (i) Current clinical records shall be completed promptly and those of discharged residents shall be completed within seventy (70) days of the discharge date. Based on record review and interview the facility failed to ensure the records of the discharged residents had a nursing discharge summary for 1 of 2 closed records. [Resident #63] Findings include: Resident #63 closed record was reviewed on 6/28/12 at 10 A.M. The record did not have a nursing discharge summary including the reason resident admitted, progress of resident, any concerns prior to discharge. A request was made to the DHS (Director Health Services) 6/28/12 on 11:00 A.M. for a discharge summary for the resident. The DHS provided an MDS (Minimal Data Set) indicating ' Nursing Home Discharge (ND) Item Set'. The MDS did not have any information summarizing the resident's stay, why they were there, progress or any concerns regarding the resident.	F9999	Concern 11. Resident 63 is a closed record. 2. Residents currently discharged will have the discharge recapitulation form completed within 70 days of discharge. 3. Medical records or designee will audit discharged residents within the past 70 days to ensure a discharge summary is completed.4. Medical records will present audited information monthly to QA &A committee for policy adherence evaluation.Concern 2.1. All missing information form noted employee files were corrected by 7/6/12.2. Business office audited all current employee files. Missing information list were given to hiring managers to locate needed documents and have completed by 7/29/12.3. Business office will inservice all hiring managers on all information needed for employee personnel files. Business office will keep new employee files in temporary storage and notify hiring managers of missing, incomplete information. New employee files will not be placed with completed employee files untill all information needed is present.4. Business office manager will report to QA&A committee monthly to discuss policy adherence.	07/29/2012

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	The nursing notes did not have a summary giving any information summarizing the resident's stay, why they were there, progress or any concerns regarding the resident. On 6/28/12 at 5:30 P.M. in an interview with the DHS, she indicated corporate told them the MDS discharge is all they had to do and no longer do nursing discharge summaries. 3.1-50(a) 2. 3.1-14 Personnel (p) Initial orientation of all staff must be conducted and documented and shall include the following: (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to resident's rights.			

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	(10)(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD),...The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis.....the baseline tuberculin skin testing should employ the two-step method.... Based on record review and interview, the facility failed to ensure employees were tested for tuberculosis [TB], had the second step of the TB testing or an annual TB test. The employee files were missing references checks, a signed job description, physical exams, job specific orientations, and Resident Rights acknowledgement. [EVS (environmental services) #1, LPN #2 and 6, RN #3 and CNA #4 and 5] Findings include: Employee records were reviewed on 6/28/12 at 11:30 A.M. using the list of employees received from the Executive			

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	Director, on 6/27/12 at 9:00 A.M. The following items were not found or supplied by the facility upon request: 1. No reference checks for new employees: LPN #2, hired 5/16/12; RN #3, hired 4/11/12; CNA #4, hired 4/20/12, and CNA #5, hired 5/9/12. 2. No TB testing of new employees: LPN #2, hire date 5/16/12 and CNA #5, hire date 5/9/12 3. No annual TB skin test: LPN #6, hire date 2/6/06. 4. No second step TB testing: CNA #4, hire date 4/20/12. 5. No physical exam prior to employment: CNA #4, hire date 4/20/12. 6. No signed acknowledgement of Resident Rights: CNA #4, hire date 4/20/12. 7. No signed job description: CNA #5, hire date 5/9/12. 8. No job specific job orientation: EVS #1, hire date 4/4/12; LPN #2, hire date 5/16/12; RN #3, hire date 4/11/12 and CNA #5, hire date 5/9/12.			

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	During an interview with office employee #11, on 6/28/12 at 3:15 P.M., she indicated LPN #6 had transferred from a sister facility, we don't have her last years TB information. During an interview with the Director of Healthcare Services, on 6/28/12 at 6:00 P.M., she indicated there was no other information regarding the TB testing, reference checks, job descriptions, job specific orientation, physical exams or resident rights acknowledgement that could be found. 3.1-14(a)			

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R0216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure weights were taken and recorded, upon admission. This affected 1 of 7 records reviewed for admission weight. (Resident #2) Findings include: 1. The clinical record for Resident #2 was reviewed on 6/28/12 at 11:10 A.M. Diagnoses for Resident #2 included, but were not limited to, panic disorder, esophageal dysphasia, chronic fatigue, anxiety disorder, hypothyroidism, fall history, and back pain. On 6/28/12 at 11:00 A.M., an interview LPN #6 indicated weights were documented on the Evaluation and	R0216	1, Resident # 2 discharged to home on 7/6/122. Current residents have been audited to ensure current assessment is completed. 3. All licensed nurses have been inserviced on completion of admission assessments. 4. Director Health Services (DHS)and/or designee will audit new admissions and readmissions during clinical meeting 5 days per week for 2 months then 4 days a week for 2 months and 3 days per week for 2 months. Audits will be presented to the QA&A committee monthly for accuracy of admissions for 6 months.	07/29/2012

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	Service Plan, which are completed at admission. An admission weight was not documented for Resident #2 on the Evaluation and Service Plan dated 6/20/12.			

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were completed for 3 of 5 residents reviewed for service plans (Residents #1, 2, and 5) and ensure service plans were signed by the resident for 2 of 5 residents reviewed for signed service plans (Residents #1 and 2).	R0217	1. Resident #2 discharged to home on Residents #1 and #5 evaluation and service plans have been reviewed for accuracy and reviewed with resident and signature obtained after review of service plan2. All current residents service plan have been audited to ensure resident has signed after review of plan. 3. All	07/29/2012

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	Findings include: 1. The clinical record for Resident #2 was reviewed on 6/28/12 at 11:10 A.M. Diagnoses for Resident #2 included, but were not limited to, panic disorder, esophageal dysphasia, chronic fatigue, anxiety disorder, hypothyroidism, fall history, and back pain. An Evaluation and Service Plan document dated 6/20/12 indicated an evaluation was completed but a service plan was not. During an interview with the DHS on 6/28/12 at 4:00 P.M., she indicated an evaluation was completed for Resident #2, but a service plan was not in place. The service plan was not signed by the resident. 2. The clinical record for Resident #1 was reviewed on 6/28/12 at 12:00 P.M. Diagnoses for Resident #1 included, but were not limited to, atrial fibrillation, diabetes mellitus, high blood pressure, and hypothyroidism. An Evaluation and Service Plan document dated 6/10/12 indicated an evaluation was completed but a service plan was not. During an interview with		licensed nurses have been inserviced on completion of service plans and review with resident and obtain resident signature. All admission/readmission service plans will be reviewed and audited in clinical meeting for completion by DHS or designee 5 days a week for 2 months, 4 days a week for 2 months and 3 days per week for 2 months. 4. Audits will be presented to the QA&A committee monthly for accuracy of admissions and service plan completion for 6 months.	

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	the DHS on 6/28/12 at 4:00 P.M., she indicated an evaluation was completed for Resident #1, but a service plan was not in place. The service plan was not signed by the resident. 3. The clinical record for Resident #5 was reviewed on 6/28/12 at 3:15 P.M. Diagnoses for Resident #5 included, but were not limited to, high blood pressure, anxiety, diabetes mellitus, chronic kidney disease-stage 3, and coronary artery disease. During clinical record review, evidence of a service plan was not apparent. An Evaluation and Service Plan document indicated an evaluation was completed but a service plan was not. During an interview with the DHS on 6/28/12 at 4:00 P.M., she indicated an evaluation was completed for Resident #5, but a service plan was not in place.			

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure cleanliness, proper food labeling and storage in the main kitchen and in the Legacy (memory care) kitchen. These deficiencies had the potential to affect 46 of 46 residents who dine from these kitchens. Findings include: 1. During the main kitchen tour on 6/25/12 at 10:40 A.M. with the Director of Food Services (DFS), the following were found without a label and without a date of opening: In the freezer: 3 frozen hamburger patties in a Ziploc bag, one brown bag of frozen tater tots, and frozen potato fries in a Ziploc bag. In the refrigerator: 33.8 ounce container of lime juice, 16 ounce container of low sodium chicken base, hot dogs in a Ziploc bag, and two 16 ounce plastic containers of strawberries. In dry storage: an opened bag of whole	R0273	1. All unlabeled, undated food items identified were immediatley destroyed. All areas identified as being dirty were immediatley.2. All residents have the potential to be affected by this deficient practice.3. All dietary staff will be inserviced by home office dining services support on kitchen sanitation and rules of food labeling, including dating of opened item. Director of Food Services(DFS) has developed and implemented a new individualized cleaning schedule with a check off system. DFS, ADFS or designee will inspect kitchen daily and compare with cleaning schedule to assure persons responsible for cleaning specific areas have done so. 4. As current QA&A member, DFS will review with committee monthly the kitchen sanitation inspections for policy adherence.	07/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	06/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	grain brown rice, and an opened bag of elbow macaroni. During the main kitchen tour, an interview with the DFS indicated all opened items needed a date of opening and a label for contents. She indicated she was on vacation last week, but, the kitchen staff should have dated and labeled these items. She indicated the main kitchen serves the health care residents and the assisted living residents. 2. During the main kitchen tour on 6/25/12 at 10:40 A.M. with the DFS, the kitchen was not clean. Floors were dirty, sticky, and debris covered. 4 of 4 stainless steel shelves were dusty and contained debris. Clean dishes, as indicated by the DFS, were stored on a lower level stainless steel shelf that was dusty and had debris on it. The knife storage wall unit was covered with debris at the top. The ice cream cooler sliding doors were sticky and covered with ice cream smears. During the main kitchen tour, an interview with the DFS indicated a stainless steel shelf was dirty and should not have clean dishes stored on it. She indicated she was on vacation last week and the kitchen staff left a mess for her to clean.			

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	3. During the Legacy kitchen tour on 6/25/12 at 11:40 A.M., with chef #15, the following were found without a label and without a date of opening: In the freezer: frozen potato fries in a Ziploc bag. In dry storage: a 5 pound bag of flour was opened and contained in a Ziploc bag. During the Legacy kitchen tour, an interview with chef #15 indicated all items should be dated once they are opened.			